Public Health
Prevent. Promote. Protect.
Foster County Public Health

2024-2025 RESPIRATORY VACCINE ADMINISTRATION RECORD

NDIIS Provider #46

Foster County Public Health
881 Main Street, Carrington, ND 58421
(701) 652-3087

Patient's Name (First, Middle Initial, Last):			Race: (Check Box) ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other ☐ Unknown
Hispanic or Latino: ☐ Yes ☐ No	Date of Birth:	Age:	
Gender: ☐ Male ☐ Female	Primary Telephone No.:	Telephone Number Type: ☐ Home ☐ Mobile ☐ Work	
Address (Street or P.O. Box):		City:	State: ZIP Code:
County of Residence:	Birth State Birth Country		Name of Person Financially Responsible:
Emergency Contact Name:	Relationship:		Phone:

Insurance Information

VFC ELIGIBLE	NOT VFC Eligible
☐ Alaskan Native ☐ No Insurance ☐ Underinsured (Vaccines not covered by insurance) ☐ Native American ☐ Medicaid – Enter Number _____	☐ Insured (Vaccines covered – Not VFC eligible) Name of Insurance: _____ State of Insurance: _____

Insurance Policy Holder: Last Name_____ First Name_____ Middle Initial____

Insurance Policy #: _____ Policy Holder: Date of Birth_____ Relationship to Client_____

Policy Holder: Address same as client? □ Yes □ No If different, please provide_____

Screening Questions for person getting Vaccinated.

Are you sick today?	☐YES	☐NO	☐DON'T KNOW
Do you have allergies to medications, food, a vaccine component, or latex? List:	☐YES	☐NO	☐DON'T KNOW
Have you ever had a serious reaction after receiving a vaccination?	☐YES	☐NO	☐DON'T KNOW
Do you have a long-term health problem with heart disease, lung disease, (e.g., asthma), kidney disease, neurologic or neuromuscular disease, liver disease, metabolic disease (e.g., diabetes), anemia or another blood disorder? Any long-term use of aspirin?	☐YES	☐NO	☐DON'T KNOW
Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?	☐YES	☐NO	☐DON'T KNOW
Have you had a seizure, brain or other nervous system problems including Guillain-Barre (paralyzing polio)? For a child has sibling or parent had a seizure?	☐YES	☐NO	☐DON'T KNOW
During the past year, have you received a transfusion of blood or blood products or been given immune (gamma) globulin or an antiviral drug?	☐YES	☐NO	☐DON'T KNOW
For women: Are you pregnant or is there a chance you could become pregnant during the next month?	☐YES	☐NO	☐DON'T KNOW
Have you received any vaccinations in the past 4 weeks?	☐YES	☐NO	☐DON'T KNOW
Have you had shingles within the last year?	☐YES	☐NO	☐DON'T KNOW
In the past 3 months, have you taken medication that affects your immune system such as prednisone, other steroids, or drugs for the treatment of cancer, rheumatoid arthritis, Crohn's disease, psoriasis, radiation treatment, or COVID-19 treatment?	☐YES	☐NO	☐DON'T KNOW
Do you currently smoke, chew, vape or have exposure to secondhand smoke?	☐YES	☐NO	☐DON'T KNOW
For babies: Have you ever been told he/she has had intussusception?	☐YES	☐NO	☐DON'T KNOW
Are you a prior ☐smoker, ☐chewer, ☐electronic nicotine user/vape/JUUL? Quit date: _____ Quitline Referral Yes☐ N/A☐ Referral Refused☐	☐YES	☐NO	☐DON'T KNOW

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Name: _____ **DOB:** _____

(Please initial) CONSENT/ACKNOWLEDGEMENT, AUTHORIZATION & ASSIGNMENT OF BENEFITS

_____ I authorize the release of any medical or other information necessary to process this claim. I consent to data entry into NDIIS (North Dakota Immunization Information System) registry. Information collected on this form will be used to document authorization of receipt of vaccine(s). Information may be shared through the North Dakota Immunization Information System (NDIIS) with other entities in accordance with North Dakota Century Code 23-01-05.3.

_____A copy of the appropriate Centers for Disease Control and Prevention Vaccine Information Statement(s) (VIS) or the Emergency Use Authorization (EUA) Fact sheet has been provided. I have read, or have had explained, the information about the disease(s) and the vaccine(s) listed below. There was an opportunity to ask questions, and all questions were answered satisfactorily. I believe that I understand the benefits and risks of the vaccine(s) cited and ask that the vaccine(s) listed below be given to me or to the person named above (for whom I am authorized to make this request.

_____ If I am the Client, or an individual legally obligated to pay for medical services provided to the Client or a Guarantor of payment, I agree to pay and I am financially responsible for the Local Public Health Unit's established charges provided to the Client not covered by a third-party payer.
I assign and authorize any third-party payer/insurer to make direct payment to the Local Public Health Unit of all benefits payable for the Client's care. (Minor not allowed to sign)

X_____ _____ _____

Signature of patient or responsible person **Relationship to patient** **Date**

(Please sign)

---------- **PLEASE DO NOT WRITE BELOW THIS LINE** ----------

Date/Time Vaccine Administered: ☐ **Patient refused to wait x 15 minutes post-vaccination.**

X	Vaccine	VIS/EUA Date	Manufacturer	Lot Number	Route	Administration Site	Nurse Signature
	INFLUENZA						
	Fluzone (3) Private MDV 0.5 ml 6 months+	08/06/2021	SFP		IM	L Deltoid / Thigh R Deltoid / Thigh	
	Fluzone High Dose (HD) SDS 0.5ml Private adult	08/06/2021	SFP		IM	L Deltoid / Thigh R Deltoid / Thigh	
	FluMist Private 0.1ml/nare 2 years-49 years	08/06/2021	MI		IN	Bilateral nares	
	Flucelvax SDS 0.5 ml VFA	08/06/2021	Seqirus		IM	L Deltoid / Thigh R Deltoid / Thigh	
	Fluzone SDS 0.5 ml VFC	08/06/2021	SFP		IM	L Deltoid / Thigh R Deltoid / Thigh	
	FluMist 2 years-49 years 0.1ml/nare VFC/VFA	08/06/2021	MI		IN	Bilateral nares	
	RSV						
	Arexvy 60+ RSV SDV 0.5ml Private adult	10/19/2023	GSK		IM	L Deltoid / Thigh R Deltoid / Thigh	
	0-5 kg Beyfortus **50 mg** PP	10/19/2023	SFP		IM	L Thigh or R Thigh	
	5+kg Beyfortus ped **100 mg** Unit 1 PP	10/19/2023	SFP		IM	L Deltoid / Thigh R Deltoid / Thigh	
	5+kg Beyfortus ped **100 mg** Unit 2 PP	10/19/2023	SFP		IM	L Deltoid / Thigh R Deltoid / Thigh	
	COVID-19						
	Pfizer 24-25 formulation Private SDS 0.3 ml 12+years	08/22/2024	PFR		IM	L Deltoid / Thigh R Deltoid / Thigh	
	12+years VFA	08/22/2024 08/2024	PFR MOD		IM	L Deltoid / Thigh R Deltoid / Thigh	
	Moderna 24-25 formulation Private SDS 0.25 ml 6 months-11 years	08/2024	MOD		IM	L Deltoid / Thigh R Deltoid / Thigh	
	Pfizer 24-25 formulation VFC MDV 0.3 ml 6 months-4 years **MUST DILUTE/Multi-dose vial**	08/22/2024	PFR		IM	L Deltoid / Thigh R Deltoid / Thigh	
	Pfizer 24-25 formulation VFC SDV 0.3 ml 5 years - 11 years	08/22/2024	PFR		IM	L Deltoid / Thigh R Deltoid / Thigh	
	OTHER						
					IM SQ	L Deltoid / Thigh R Deltoid / Thigh	
					IM SQ	L Deltoid / Thigh R Deltoid / Thigh	

Route: IM = Intramuscular SQ = Subcutaneous IN = Intranasal
Manufacturer: MOD = Moderna, PFR = Pfizer, SFP= Sanofi Pasture, GSK= GlaxoSmithKline, MI = MedImmune
Administration Site (Where Vaccine Was Given): L = Left R = Right
ml = milliliter

MDV = Multi Dose Vial
PFS = Pre-Filled Syringe
HD = High Dose
N/A = Not Applicable **PP** = Pediatric Private